parts. The author gives statistics to show that the ratio of the length of the feet and of the head to the total length of the body is decidedly greater in this affection than in the normal condition, or in the case of two giants to whom he refers. The cause of the disease is not clear. As it is evidently, for reasons which he explains, not to be included under leontiasis osseum, osteitis deformans, or arthritis deformans, it is best considered as an independent disorder.

Caseous Concretions of the Tonsils.

Under this title V. Gautier (*Rev. Méd. de la Suisse, Romande*, 1889, No. 1, 21) describes the very abnormal distention of the crypts of the tonsils with cheesy matter. He knew of no literature upon the affection until the recent monograph of Jacobson came to his notice, containing a report of a case, and a bibliography of the subject. Jacobson calls it "Algosis faucium leptothricia," since it has been discovered that the caseous masses consist chiefly of leptothrix buccalis. He collected seventeen cases from German medical literature, and added three of his own observation. The presence of these accumulations is rarely attended by fever or even dysphagia. Gautier relates the case of a woman in whom these masses resembling perfectly white buttons, which formed one or two at a time on the tonsils, and after reaching the size of a pea or bean detached themselves and fell on the base of the tongue. There were absolutely no subjective symptoms, except a slight malaise felt one or two evenings before the day on which the masses were discharged. She sought treatment on account of the very unpleasant odor which the liberated substance possessed. A portion examined microscopically on one occasion consisted of a dense, felt-like mass of leptothrix threads with cellular débris. The treatment consisted in incising the anterior wall of the crypts, emptying them, and cauterizing them with a solution of chromic acid.

Recurrent Pneumothorax.

Samuel West (*Brit. Med. Journ.*, Jan. 12, 1889) reports an interesting example of this condition. The patient, an apparently healthy man of twenty-two years of age, had for some days suffered from shortness of breath, which he had first noticed on getting out of bed in the morning. Physical examination of the chest clearly revealed the presence of pneumothorax without effusion, and in the process of resolution. The dyspnœa was so slight that the patient rebelled against being kept in bed. The subsequent history of the case is simple, as recovery went steadily onward, and in the course of a month the difference between the two sides of the chest was scarcely perceptible. The previous history of the patient was good, and there was no disease to which the development of the pneumothorax could be attributed. The interesting part of the story is, that about six months before, while walking quietly, he had been suddenly seized with pain below the clavicle, shortness of breath, and cough, incapacitating him from all hurry and great exertion for about a fortnight. About three months after this he again became short of breath on the morning after playing football violently, and continued so for a month. These two previous attacks were stated to have been exactly similar to the one observed by West, and the strong probability is that they were due to pneumothorax. The authors refers to the case reported by Gabb, in the *British Medical Journal*, some months previously, and states that these two cases show that a patient may have repeated attacks of pneumothorax and yet recover. He also calls attention to two facts well established but not generally known, and which this case illustrates; namely, that pneumothorax not infrequently occurs in the apparently healthy, and that it may develop in a latent, insidious way, without the violent symptoms often seen.

TREATMENT OF SUFFOCATIVE PNEUMOTHORAX BY PERMANENT THORACIC FISTULA.

BOUVERST (*Bull. Méd.*, 1889, No. 7, 107) has recently witnessed two cases of pneumothorax which he denominates "suffocative," in which the chief symptom consisted of an intense dyspnœa increasing constantly without any remission, and terminating rapidly in death by asphyxia. Both the clinical and post-mortem examinations showed that the air in the pleural cavity was under a high degree of tension. The author says that it is impossible that the increased tension can be due to air entering the pleural cavity during inspiration, as has been stated by various writers, and claims that the entrance occurs during cough, when the tension in the bronchial tubes is very greatly raised. Cough is consequently very dangerous in pneumothorax, and is to be combated by full doses of opium; but in cases of suffocative pneumothorax this will be insufficient. In such a case the indication is to evacuate the air, just as one would evacuate a huge pleural effusion. A simple puncture is not enough, as the air at once begins to reaccumulate. The author therefore recommends and has practised the making of a permanent fistula, leaving the canula in position. This must be done under antiseptic precautions, using a canula 4 cm. long and 3 mm. in diameter. An antiseptic dressing should be applied, in order to prevent, as far as possible, the formation of a pyothorax.

THE GRAPHIC RECORD OF PHYSICAL SIGNS IN THE INVESTIGATION OF HEART DISEASE.

A very valuable article on this subject is contributed by A. E. SANSOM (*Lancet*, Jan. 19, 1889). He lays great stress on the necessity of precision of observation and of precision of record, but says that this is to be attained with the expenditure of as little time as possible. The dress must be completely removed from the chest, and this protected from cold by a warm wrap. The patient must then be placed in such a position that both sides of the thorax are presented in like conditions. As the impressions conveyed to the ear are more fleeting than those recorded by the eye, it is necessary to indicate visibly the physical signs discovered; and for this purpose an aniline pencil, or, still better, a dermatographic pencil, may be used.

It is carefully noted by *inspection* whether the apex beat is visible, and if so, dots are to be made with the pencil over the area where it is observed. Pulsation in the epigastrium, regions of the aorta or pulmonary artery, or in the vessels of the neck, is denoted by the sign "pn" at the point where it is seen.